

**NOTICE OF INJURY LEAVE RESTORATION**  
**April 1, 2000 through July 31, 2002**

This completed form must be returned within **10 working days** of receipt of this notice.

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

SSN: \_\_\_\_\_

FROM: \_\_\_\_\_

**Department Use Only**

Facts (e.g., date, duration, and type of illness/injury)

Calculation (e.g., what happened and what should have happened had injury leave been applied in terms of time, month, or both)

Net Amount Owed by Whom (e.g., amount of leave and/or money owed to the state or employee)

Implementation Plan (e.g., repayment schedule, date leave will be restored, etc.)

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**Employee Election**

- ☐ I elect to have injury leave restored to me as set forth in this notice. I understand that this is the full injury leave benefit to which I may be entitled for the work-related illness/injury covered by this notice. I further understand that any money I am owed by the state will be reduced by (1) any money I owe to the state and (2) any applicable deductions such as taxes and PERA.
- ☐ I decline to have injury leave restored to me for the work-related illness/injury covered by this notice. I understand that this is my only opportunity to make such an election.

**I understand that the decision regarding my election could have legal consequences and that I may consult with my legal representative at my expense before signing this election.**

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name